Received via electronic mail 03/16/23

The following is a summary of the Plan of Correction for Harmony at Greensboro Assisted Living. This Plan of correction is in regards to the Corrective Action Report dated 2/28/2023. This plan of correction is not to be constructed as an admission of or an agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .1004 (a) Medication Administration

(a) An adult care home shall assure that the preparation and administration of medications, prescription and non – prescription, and treatments by staff are in accordance with:
   1. Orders by a licensed prescribing practitioner which are maintained in the resident's record; and
   2. Rules in this Section and the facilities policies and procedures.

The community HCD/Designee will pull 5 random MARS weekly to ensure accurate orders and administration. HCD/Designee will meet routinely with the RN Consultant to ensure accuracy in orders at a frequency no less than once a month. The preferred pharmacy will provide permissions through the electronic medication record to be set so that any time changes are limited to HCD/Designee. In addition, parameters will be flagged by the preferred pharmacy for a validation step with med administration pass. Plan of Correction to be Completed By: April 15th, 2023.

10A NCAC 13F .1004 (i) Medication Administration

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and the observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

The community has taken immediate action with team members to review Medication Administration Policy. Medication Administration Review Class was provided in February and March by the Preferred Pharmacy. In addition, the HCD/Designee will routinely, at no less than once a week, walk resident rooms to ensure that medications are being administered as ordered and observe they are being taken prior to record of medication administration.

Correction date April 15, 2023 per conversation with Administrator 03/17/23. SG.

Reviewed and acknowledged 03/17/23. SG

Received via electronic mail 03/16/23

PRINTED: 02/27/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041086	A. BUILDING: _____ B. WING _____	R 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 02/08/23 to 02/09/23.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 2 of 5 sampled residents (#2 and #1) who had orders for a blood pressure medication with a parameter to hold the medication for heart rate less than 70, and for an anxiety medication to be taken at specific times during the day (Resident #2), and who had orders for a cholesterol medication to be administered at bedtime (#1). The findings are: 1. Review of Resident #2's current FL2 dated 09/27/22 revealed diagnoses included anxiety and depression, history of stroke with residual deficit, hypertension, labile (easily altered) blood pressure, and stenosis (narrowing) of intracranial portion of both internal carotid arteries. a. Review of Resident #2's current FL2 dated	D 358		

Reviewed and acknowledged 03/17/23. SG

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL041086 Y1	A. Building B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0139 Reg. # 10A NCAC 13F .0407(a)(7) LSC	Correction Completed 12/31/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Sheryl Goin	DATE 2/9/23
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/18/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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D 358	Continued From page 1 09/27/22 revealed an order for Coreg (a medication used to treat high blood pressure) 3.125mg, take one tablet twice daily. Review of Resident #2's signed physician order dated 01/05/23 revealed an order to hold Coreg for a heart rate less than 70 beats per minute (bpm). Review of Resident #2's primary care provider (PCP) Progress Note dated 01/05/23 revealed: -The PCP saw Resident #2 as a follow-up for a hospital visit on 01/02/23 due to an episode of syncope (passing out) while sitting on the commode. -There was documentation that since Resident #2 was admitted to the facility on 12/30/21 she had persistent high blood pressure. -Resident #2 was "very adverse to normotensive blood pressure control" and became very anxious if her systolic blood pressure was below 160. -Resident #2's blood pressure during the PCP's assessment on 01/05/23 was 130/70 but there was documentation her systolic blood pressures ranged from 160s-180s, and her heart rates (pulses) ranged from 60s-80s. -Resident #2 denied symptoms of chest pain, shortness of breath, dizziness or loss of balance. -The PCP's documented treatment plan for Resident #2's hypertension was to have staff hold Coreg for a heart rate of less than 70 beats per minute (bpm). Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Coreg 3.125mg twice daily, hold for heart rate less than 70, scheduled at 8:00am and 5:00pm. -There was documentation Resident #2's heart	D 358		

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D 358	Continued From page 2 rate (pulse) was less than 70 and Coreg was administered on 24 out of 52 opportunities from 01/06/23 through 01/31/23 with examples as follows: -On 01/06/23 at 8:00am, heart rate was documented as 62 and Coreg was documented as administered. -On 01/13/23 at 5:00pm, heart rate was documented as 65 and Coreg was documented as administered. -On 01/23/23 at 8:00am, heart rate was documented as 64 and Coreg was documented as administered. -On 01/31/23 at 5:00pm, heart rate was documented as 68 and Coreg was documented as administered. -Heart rate (pulse) values ranged from 59 to 101 bpm from 01/06/23 through 01/31/23. Review of Resident #2's February 2023 eMAR revealed: -There was an entry for Coreg 3.125mg twice daily, hold for heart rate less than 70, scheduled at 8:00am and 5:00pm. -There was documentation Resident #2's heart rate was less than 70 and Coreg was administered on 11 out of 16 opportunities from 02/01/23 through 02/08/23 with examples as follows: -On 02/02/23 at 5:00pm, heart rate was documented as 58 and Coreg was documented as administered. -On 02/04/23 at 8:00am, heart rate was documented as 65 and Coreg was documented as administered. -On 02/06/23 at 8:00am, heart rate was documented as 55 and Coreg was documented as administered. -On 02/08/23 at 5:00pm, heart rate was documented as 61 and Coreg was documented	D 358		

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D 358	Continued From page 3 as administered. -Heart rate (pulse) values ranged from 55 to 79 bpm from 02/01/23 through 02/08/23. Observation of medication on hand for Resident #2 on 02/09/23 at 10:00am revealed: -There were two medication cards containing Coreg 3.125mg tablets with a dispensed date of 01/17/23. -One medication card had 6 out of 31 dispensed tablets remaining, and the other medication card had 10 out of 31 dispensed tablets remaining. -There were instructions printed on the medication cards to hold Coreg for a heart rate less than 70. Interview with Resident #2 on 02/08/23 at 3:00pm revealed: -She had regular appointments with her cardiologist, but her PCP saw her more frequently and adjusted her medications for heart rate and blood pressure. -She felt groggy and weak after taking her morning medications and had reported her symptoms to all of her medication aides (MA), the Healthcare Director (HCD) and her PCP. -The PCP told her she would not adjust her medications because she did not want Resident #2 to have another stroke due to high blood pressure. -The MA checked her blood pressure and heart rate at least two times a day, sometimes more often if she asked them to. -The MAs always checked her heart rate prior to administering her medication for blood pressure. -Occasionally if her heart rate was out of range the MAs would adjust which medication they gave her but she did not know which one. Interview with a MA on 02/09/23 at 10:10am	D 358		

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D 358	Continued From page 4 revealed: -Resident #2 reported that sometimes she thought her blood pressure or heart rate were low but did not say which specific symptoms she was experiencing. -The MAs checked Resident #2's blood pressure and heart rate prior to administering her blood pressure medications including Coreg. -Resident #2's systolic blood pressure was always 150s-160s and her heart rate was always 50s-60s bpm. -She had documented administering Coreg to Resident #2 when her heart rate was less than 70 bpm eleven times in January 2023 and nine times in February 2023. -There was no pop-up notification in the eMAR system if she documented a heart rate less than 70 prior to administering Coreg. -She thought the parameter to hold Resident #2's Coreg for a heart rate less than 70 was confusing and she had not realized she was administering Coreg to Resident #2 incorrectly. -She administered Coreg to Resident #2 because she always said she wanted it even if her heart rate was low, because her blood pressure was always high. -She had just not paid attention to the instructions in the eMAR; the order asked for a heart rate prior to administration, so she checked Resident #2's heart rate, entered the information in the eMAR and administered the Coreg without realizing there was an order to hold the medication if heart rate was less than 70. -Resident #2's other blood pressure medications had instructions to hold if her systolic blood pressure was less than 110, which it was never was, so she had not noticed that the Coreg's instruction was to hold for a heart rate less than 70 bpm. -Resident #2 did not have any falls or observable	D 358		

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D 358	Continued From page 5 symptoms of having a low heart rate. Interview with Resident #2's PCP on 02/09/23 at 12:20pm revealed: -When Resident #2 went to the hospital on 01/02/23, she was not sure if she had a vasovagal episode (a sudden drop in heart rate and blood pressure due to a trigger such as straining) or a panic attack. -Resident #2 was taking Coreg to prevent her heart rate from going too high. -She had ordered Resident #2's Coreg to be held if her heart rate was less than 70 because Coreg effects heart rate more than blood pressure. -She wanted Resident #2's heart rate to be low but not into the 40s. -The manufacturer of Coreg usually recommended holding it for a heart rate less than 60 bpm. -She was not aware that Resident #2 had been administered Coreg when her heart rate was in the 50s and 60s. -A possible adverse reaction to taking Coreg with a heart rate less than 70 bpm would be a further lowering of her heart rate which could cause dizziness. -Resident #2 had reported dizziness and fatigue since she first met her; those were not new symptoms since 01/05/23, when she had written the order to hold Coreg for a heart rate less than 70 bpm. -She thought Resident #2's complaints of dizziness and fatigue were related to her anxiety more than her medications. -She did not think Resident #2's symptoms were caused from the MAs administering Coreg for a heart rate less than 70. -Each time she saw Resident #2 she checked her blood pressure and heart rate and she had never found her to be bradycardic (low heart rate).	D 358		

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D 358	Continued From page 6 -Resident #2 was usually up and walking around the facility and had a good gait and mobility. Interview with a personal care aide (PCA) on 02/09/23 at 3:10pm revealed: -Resident #2 complained of feeling dizzy or being sick or having other symptoms all of the time. -Her complaints of symptoms had not worsened since January 2023. -The MAs were aware of Resident #2's complaints of symptoms and always checked her vital signs when she reported dizziness. Telephone interview with a MA on 02/09/23 at 3:15pm revealed: -She had documented administering Coreg to Resident #2 when her heart rate was less than 70 bpm five times in January 2023 and one time in February 2023. -If she had documented Coreg as being administered she took responsibility for administering it even if Resident #2's heart rate was within the parameter to hold the medication. -There was no notification that popped up in the eMAR to hold Coreg if Resident #2's heart rate was documented as being less than 70 bpm. -She had not noticed that Coreg was being administered incorrectly. Interview with the HCD on 02/09/23 at 3:30pm revealed: -She never reviewed the residents' eMARs for accuracy. -There was a report system in the eMAR she was able to access, but it only showed missed medications or refusals, it did not show if medications were administered despite values falling outside of an ordered parameter. -There were no staff responsible for auditing the eMARs for accuracy of medication administration.	D 358		

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D 358	Continued From page 7 -She was not aware that the MAs were administering Coreg to Resident #2 when her heart rate was less than 70 bpm. -She thought the MAs were too task-driven and when the box popped up in the eMAR asking for a heart rate to be documented prior to administering Coreg to Resident #2, the MAs documented the heart rate and administered the medication without paying attention that there was an order to hold the medication. -Since Resident #2's other blood pressure medications had parameters to hold for a systolic blood pressure less than 110, she thought the MAs entered the heart rate without noticing there was a parameter to hold Coreg if the heart rate was less than 70. -Resident #2 complained of feeling groggy or dizzy since she was first admitted to the facility and her symptoms did not seem worse in the last month since the order to hold Coreg for a heart rate less than 70 bpm was added. -The PCP and Resident #2's psychiatric nurse practitioner (NP) felt her dizziness was due to her anxiety rather than her heart rate. -She expected the MAs to administer medications as ordered. Telephone interview with a representative from Resident #2's cardiology office on 02/09/23 at 4:20pm revealed: -Resident #2 was ordered Coreg 3.125mg twice daily. -The general guidance for Coreg was to hold it for a heart rate less than 60 bpm. -Possible symptoms of a low heart rate included lightheadedness or dizziness. -Resident #2 had reported feeling dizzy at her appointment there earlier that day, 02/09/23, but after an assessment the cardiologist felt her symptoms were related to not eating or drinking	D 358		

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D 358	Continued From page 8 enough that day rather than her medications. Interview with the Administrator on 02/09/23 at 4:15pm revealed: -She was not aware that Resident #2 was administered Coreg when her heart rate was beneath the threshold for holding the medication. -She expected the MAs to read medication orders completely prior to administering the medication. -The HCD and her two designated supervisors should have been completing audits of the eMARs to ensure medications were being administered as ordered. -The HCD was supposed to complete random eMAR audits each week. -She was not aware that audits of the eMAR had not been completed. -Resident #2 had complained of feeling groggy or dizzy since the Administrator met her one year prior; she had been seen by her PCP, the psychiatric NP and cardiology for those symptoms. -There had been no increase in complaints of symptoms from Resident #2 in the last month. b. Review of Resident #2's current FL2 dated 09/27/22 revealed an order for lorazepam (a Schedule IV controlled medication used to treat anxiety) 1mg take one tablet three times daily. Review of Resident #2's Psychiatric Follow-Up Evaluation note dated 01/04/23 revealed: -The psychiatric nurse practitioner (NP) had an appointment with Resident #2 for a medication check. -Resident #2's diagnoses included depression and anxiety. -Resident #2 reported to her that she thought her lorazepam could be reduced to twice daily because she no longer wanted to take the	D 358		

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D 358	Continued From page 9 morning dose. -Resident #2 agreed to only taking the lorazepam in the afternoon and at night. Review of Resident #2's signed physician order dated 01/04/23 revealed an order for lorazepam 1mg twice daily at 2:00pm and 8:00pm. Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm with a discontinue date of 01/04/23. -There was an entry with a start date of 01/05/23 for lorazepam 1mg two times daily at 2:00pm and 8:00pm, scheduled at 2:00pm and 8:00pm. -There was documentation lorazepam was administered twice daily at 2:00pm and 8:00pm from 01/05/23 through 10:00am on 01/24/23. -There was an entry for lorazepam 1mg two daily at 2:00pm and 8:00pm, scheduled at 10:00am and 8:00pm. -There was documentation lorazepam was administered twice daily at 10:00am and 8:00pm from 8:00pm on 01/24/23 through 01/31/23. Review of Resident #2's February 2023 eMAR revealed: -There was an entry for lorazepam 1mg two times daily at 2:00pm and 8:00pm scheduled at 10:00am and 8:00pm. -There was documentation lorazepam was administered twice daily at 10:00am and 8:00pm from 02/01/23 through 02/08/23. Observation of medication on hand for Resident #2 on 02/09/23 at 10:00am revealed: -There was one medication card for lorazepam 1mg tablets with instruction to administered twice	D 358		

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D 358	Continued From page 10 daily at 2:00pm and 8:00pm. -There was a dispensed date of 01/17/23 and there were 57 out of 60 tablets remaining in the card. Interview with a medication aide (MA) on 02/08/23 at 2:50pm revealed: -The pharmacy entered orders on the eMAR. -Once the pharmacy entered a medication order into the eMAR, either the Healthcare Director (HCD) or an MA could approve the order. -She had administered Resident #2's lorazepam that morning because it showed as a medication due at 10:00am, so she could administer it anywhere from 9:00am to 11:00am. -She had not noticed the order in the eMAR stated to administer lorazepam twice daily at 2:00pm and 8:00pm. Interview with Resident #2 on 02/08/23 at 9:30am revealed: -She used to take lorazepam three times per day, but it was making her groggy in the morning so they changed it to two times daily. -She used to take lorazepam twice in the afternoon, but she needed it earlier in the day, so they changed the time. -She took lorazepam to help calm her nerves. Interview with a MA on 02/09/23 at 10:10am revealed: -Resident #2 used to take lorazepam three times daily, but the doctor changed the order for her to take it at 2:00pm and 8:00pm. -Resident #2 had a lot of anxiety and could not wait until 2:00pm to take lorazepam so she changed the administration time of the first dose from 2:00pm to 10:00am. -She had asked the HCD if it was okay to change the administration time prior to doing so and was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

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D 358	Continued From page 11 told she had permission to change the administration time. Telephone interview with a representative from the facility's contracted pharmacy on 02/09/23 at 11:10am revealed: -Resident #2's lorazepam 1mg was ordered to be taken twice daily at 2:00pm and 8:00pm. -The administration time changed to 10:00am and 8:00pm on 01/24/23 by a MA at the facility. -They had not received an order at the pharmacy to change the administration time from 2:00pm to 10:00am. Telephone interview with Resident #2's psychiatric NP on 02/09/23 at 2:50pm revealed: -She had previously ordered Resident #2's lorazepam 1mg to be taken three times daily to help manage her anxiety. -Resident #2 had complained that the 8:00am dose of lorazepam was making her sleepy so she had discontinued the 8:00am dose and chose to keep the 2:00pm and 8:00pm doses. -She was not aware the MAs were administering Resident #2's lorazepam at 10:00am instead of 2:00pm. -There was no harm to Resident #2 for taking lorazepam at 10:00am instead of 2:00pm, but she would expect the staff to either administer the medication at 2:00pm and 8:00pm as ordered or contact her to discuss changing the order. Interview with the HCD on 02/09/23 at 3:30pm revealed: -Resident #2's lorazepam decreased from three times daily to twice daily because it was making her groggy in the morning. -The MA who changed the administration time of Resident #2's lorazepam did have access to changing medication administration times in the	D 358		

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D 358	Continued From page 12 eMAR. -She had given the MA approval to change the administration time from 2:00pm to 10:00am. -She thought the MA had discussed the administration time change with the psychiatric NP prior to asking permission to change the time. -The MA had not told her that the psychiatric NP was not aware of her request to have the administration time changed, and she had not thought to ask the MA. Interview with the Administrator on 02/09/23 at 4:15pm revealed: -She was not aware that Resident #2's lorazepam 1mg administration time was changed from 2:00pm as ordered, to 10:00am per resident request. -She expected the MAs to ask the HCD to contact the PCP or psychiatric NP to discuss changing a medication's administration time and have the order changed if needed. -MAs should not be changing administration times of medications, especially controlled substance drugs. -She would have expected any of the MAs to notice the lorazepam order and to administer at 2:00pm and 8:00pm, and to notify the HD of the discrepancy when the medication showed up on the eMAR as due at 10:00am. -She expected all medication orders to be read completely, and administered as ordered. 2. Review of Resident #1's current FL2 dated 08/08/22 revealed: -Diagnoses included dyslipidemia. -There was an order for atorvastatin (a medication used to lower cholesterol) 20mg 1 tablet daily. Review of Resident #1's physician's order dated	D 358		

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D 358	Continued From page 13 12/28/22 revealed an order to change the administration time for atorvastatin to bedtime. Review of Resident #1's electronic medication Record (eMAR) for December 2022, January 2023 and 02/01/23 through 02/09/23 revealed: -There was an entry for atorvastatin 20mg 1 tablet daily scheduled for administration at 8:00am. -Atorvastatin was documented as administered for 31 of 31 opportunities in December 2022, 31 of 31 opportunities in January 2023, and 9 of 9 opportunities from 02/01/23 through 02/09/23. Interview with a medication aide (MA) on 02/09/23 at 9:48am revealed: -She and the Healthcare Director (HCD) were responsible for ensuring medication orders were faxed to the pharmacy. -Once the pharmacy entered the order on the eMAR, the entry wiould appear on the eMAR as "pending" until it was approved. -MAs were responsible for approving pending orders on the eMAR. -When the pharmacy entered the order on the eMAR, sometimes the administration time defaulted to 8:00am and the MAs would have to go in and change the administration time to the correct time. -She administered atorvastatin to Resident #1 this morning on 02/09/23. -She did not notice the order for Atorvastatin 1 tablet at bedtime on the eMAR when she administered the medication; the only thing she looked at on the eMAR was the administration time of 8:00am. Telephone interview with a representative from Resident #1's pharmacy on 02/09/23 at 10:30am revealed:	D 358		

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D 358	Continued From page 14 -Resident #1 had a current order for atorvastatin 20mg 1 tablet daily for cholesterol. -The pharmacy did not receive an order dated 12/28/22 to change the administration of atorvastatin from daily to bedtime. -Atorvastatin would be more effective if administered at bedtime, and it would be better absorbed. -Atorvastatin 20mg was dispensed to the facility on 12/13/22 with a quantity of 30 tablets, on 01/12/23 with a quantity of 30 tablets, and on 02/08/23 with a quantity of 30 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 02/09/23 at 11:19am revealed: -The pharmacy did not fill Resident #1's medications; the pharmacy only profiled Resident #1's medications by entering them on the facility's eMAR. -The pharmacy received an order 12/28/22 to change atorvastatin 20mg from 1 tablet daily to 1 tablet at bedtime. -The pharmacy entered the order for atorvastatin 20mg 1 tablet at bedtime on the eMAR, but the pharmacy did not change the administration time. -The Administration time should have been changed to 8:00pm for bedtime administration. -The facility had the capability to change the administration time on the eMAR if it was not correct. -The facility had not contacted the pharmacy about an incorrect administration time for atorvastatin. Interview with Resident #1's primary care provider (PCP) on 02/09/23 at 12:52pm revealed: -She wrote an order for the administration time for atorvastatin to be changed to at bedtime because the body absorbs all statin medications	D 358		

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D 358	Continued From page 15 better at night. -She did not know Resident #1 was still being administered atorvastatin at 8:00am. -She preferred Resident #1 to be administered the evening dose of atorvastatin because it worked better. Interview with the HCD on 02/09/23 at 3:22pm revealed: -She reviewed the order dated 12/28/22 to change the administration time for atorvastatin to bedtime. -She sent the order to the pharmacy and one of the MAs approved the order to change the administration time, but the administration time was not changed. -She did not review the eMAR to see if the time had been changed. -The pharmacy usually changed the administration time when they entered the medication orders on the eMAR. -The MA who approved the eMAR entry for the time change for atorvastatin should have changed the time to bedtime dosing if the pharmacy had not. -She and the MAs had the ability to change medication administration times. -She reviewed missed medication reports, refusal reports, and reports of medications not administered, but she had not completed an eMAR audit. Interview with the Administrator on 02/09/23 at 4:14pm revealed: -The HCD and the MAs were responsible for reviewing medication orders entered on the eMAR for accuracy. -She expected the HCD or a MA to change the time of administration of atorvastatin according to the PCP's order.	D 358		

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D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medication aides observed residents taking their medication for 2 of 5 sampled residents (#2 and #1) who had medications left in their rooms. The findings are: 1. Review of Resident #2's current FL2 dated 09/27/22 revealed: -Diagnoses included anxiety and depression, history of stroke with residual deficit, and hypertension. -There was an order for lorazepam (a Schedule IV controlled medication used to treat anxiety) 1mg take one tablet three times daily. Review of Resident #2's signed physician order dated 01/04/23 revealed an order for lorazepam 1mg twice daily. Review of Resident #2's admission orders sheet dated 11/29/21 revealed: -There was documentation Resident #2 was not capable of self-administering medications and did	D 366		

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D 366	Continued From page 17 not know her doses or times of administration for her medication. -There was documentation Resident #2 could not handle order changes and would not remember to keep her medications secured. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg twice daily scheduled at 10:00am and 8:00pm. -There was documentation lorazepam was administered on 02/08/23 at 10:00am. Observation of Resident #2's room on 02/08/23 at 9:32am revealed: -Resident #2 was alone in her room; she walked out of her bathroom and sat down on the side of her bed. -There was a nightstand next to her bed. -On top of the nightstand was a clear plastic cup filled halfway with water and a small paper cup containing one pill inside. -The pill was white, round, scored down the center with the letters EP on one half and the numbers 905 on the other half of the pill. -Resident #2 took the pill with a drink of water at 9:36am. -At 9:38am two staff personnel knocked on Resident #2's door and entered the room. Interview with Resident #2 on 02/08/23 at 9:33am revealed: -The pill on her nightstand was Ativan (name brand lorazepam) 1mg, her "nerve pill." -Sometimes the medication aides (MA) left it in her room because she did not always want to take it right away when they brought it to her. -The MAs knew if she did not take her Ativan she would start crying and carrying on, so they	D 366		

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D 366	Continued From page 18 sometimes left it for her to take when she wanted it. -She took Ativan 1mg two times per day. Interview with a MA on 02/08/23 at 2:50pm revealed: -She had administered lorazepam 1mg to Resident #2 that morning. -She took the pill into Resident #2's room and had an emergency with another resident's call light was going off, so she left Resident #2's room prior to watching Resident #2 take the medication. -She had dropped the lorazepam tablet off in Resident #2's room around 9:15am and checked on Resident #2 around 9:30 to make sure she had taken the medication. -She did not know if there was a facility policy regarding leaving medication in a resident's room without watching them take it. -She was trained upon hire at the facility that MAs were not supposed to leave medication in a resident's room, but she thought answering the other resident's call light took priority. -She did not leave lorazepam in Resident #2's room any other time and that morning was an isolated incident due to the call light going off. Interview with a MA on 02/09/23 at 10:10am revealed: -Resident #2 asked her to leave lorazepam in her room before and told her she would take it whenever she was ready to. -She had never left lorazepam in Resident #2's room because she and all the other MAs were trained that they were supposed to watch each resident taking their medications. Interview with Resident #2's primary care provider (PCP) on 02/09/23 at 12:20pm revealed:	D 366		

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D 366	Continued From page 19 -Resident #2 had anxiety and was taking lorazepam to help treat it. -Resident #2 could not be trusted to take lorazepam safely on her own. -The MAs should be administering lorazepam to Resident #2 and watching her take the medication prior to leaving the room. Interview with a personal care aide (PCA) on 02/09/23 at 1:15pm revealed she had never seen a cup of pills or any medication left in Resident #2's room. Telephone interview with Resident #2's psychiatric nurse practitioner (NP) on 02/09/23 at 2:50pm revealed: -Resident #2 was taking lorazepam to treat her anxiety. -Resident #2 was alert and oriented and could probably take lorazepam on her own, but there had been no discussion or self-administration of medication assessments done. -The MAs should administer lorazepam to Resident #2 as ordered. Interview with the Healthcare Director (HCD) on 02/09/23 at 3:30pm revealed: -The MAs were all aware that they were expected to wait and watch each resident take their medications. -She expected the MAs to only document the administration of medication that they witnessed the residents taking, because otherwise there was no way to prove the resident actually took the medication. -She had been made aware the previous morning, 02/08/23, that the MA had left lorazepam in Resident #2's room. Interview with the Administrator on 02/09/23 at	D 366		

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D 366	Continued From page 20 4:15pm revealed: -She was not aware of medication being left in Resident #2's room. -She expected the MAs watch and observe all medications being taken by the resident prior to documenting they were administered. -Part of the MA's training when they were hired included never leaving medications in a resident's room. 2. Review of Resident #1's current FL2 dated 08/08/22 revealed: -Diagnoses included acute congestive heart failure, coronary artery disease, anxiety, myofascial pain syndrome, debility, pleural effusion, bilateral lower extremity edema, osteoarthritis of the left hip, dyspnea, hypothyroidism, deep groin pain, bilateral leg weakness, arthritis, hypertension, dyslipidemia, and atrial fibrillation. -There was an order for amiodarone 200mg one-half tablet every day used to treat irregular heartbeat). -There was an order for antacid chewable tablet 500mg 1 tablet twice daily (used to treat indigestion). -There was an order for atorvastatin 20mg 1 tablet every day (used to treat high cholesterol levels). -There was an order for Eliquis 5mg 1 tablet twice daily (used to prevent serious blood clots from forming). -There was an order for gabapentin 300mg 1 tablet 3 times daily (used to treat nerve pain). -There was an order for hydrocodone-acetaminophen 5-325mg one-half tablet 3 times daily (used to treat moderate pain). -There was an order for metoprolol 25mg one-half tablet daily (used to treat high blood pressure).	D 366		

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D 366	Continued From page 21 -There was an entry for oyster shell 500-vitamin D3 200 1 tablet daily (used to prevent and treat low calcium blood levels). -There was an entry for pantoprazole 40mg 1 tablet daily scheduled for administration at 8:00am (used to treat acid reflux). -There was an entry for polyethylene glycol 3350 powder mix 17gm in 6 ounces of juice and drink every day (used to treat constipation). -There was an entry for risa-bid caplet 1 tablet twice daily (used to treat bowel problems). -There was an entry for spironolactone 25mg 1 tablet daily (used to treat high blood pressure and heart failure). -There was an entry for torsemide 20mg 2 tablets twice daily (used to treat reduce extra fluid in the body). Review of Resident #1's physician's orders dated 08/11/22 revealed there was an order to start gabapentin 250mg/5ml solution give 6ml 3 times daily and discontinue gabapentin 300mg 3 times daily. Review of Resident #1's physician's orders dated 10/06/22 revealed an order to start pantoprazole 20mg daily and discontinue pantoprazole 40mg. Review of Resident #1's electronic Medication Administration Record (eMAR) for 02/01/23 through 02/09/23 revealed: -There was an entry for amiodarone 200mg one half tablet every day scheduled for administration at 8:00am -There was an entry for antacid chewable tablet 500mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for atorvastatin 20mg 1 tablet every night at bedtime scheduled for administration at 8:00am (wrong time entered	D 366		

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D 366	Continued From page 22 and documented on the eMAR). -There was an entry for Eliquis 5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry gabapentin 250mg/5ml solution give 6ml twice daily scheduled for administration at 8:00am and 2:00pm. -There was an entry for hydrocodone-acetaminophen 5-325mg one half tablet 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was an entry for metoprolol 25mg one half tablet daily scheduled for administration at 8:00am. -There was an entry for oyster shell 500-vitamin D3 200 1 tablet daily scheduled for administration at 8:00am. -There was an entry for pantoprazole 20mg 1 tablet daily scheduled for administration at 8:00am. -There was an entry for polyethylene glycol 3350 powder mix 17gm in 6 ounces of juice and drink every day scheduled for administration at 8:00am. -There was an entry for risa-bid caplet 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for spironolactone 25mg 1 tablet daily scheduled for administration at 8:00am. -There was an entry for torsemide 20mg 2 and one-half tablets (50mg) twice daily scheduled for administration at 8:00am and 8:00pm. Observation of Resident #1's room during the initial tour of the facility on 02/08/23 at 9:00am revealed: -Resident #1 was sitting in her recliner chair in her living area. -There was a side table next to her chair and on	D 366		

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HARMONY AT GREENSBORO	3420 WHITEHURST ROAD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 23 the side table was a medication cup filled with applesauce and crushed medications, a plastic medication cup containing a liquid, and a plastic drinking cup containing a liquid. -There was no staff present in Resident #1's room. Interview with Resident #1 on 02/08/23 at 9:02am revealed: -She was in the bathroom when the medication aide (MA) came by her room; the MA left her medication on her side table. -One of the plastic medication cups contained her morning medication which had been crushed in applesauce. -She did not know which medications were crushed in the applesauce without looking at a list of her medications. -The other plastic medication cup contained liquid gabapentin. -The plastic drinking cup contained water and polyethylene glycol. -Sometimes the MAs left medication in her room for her to take and sometimes they watched her take it. Interview with the MA on 02/08/23 at 4:36pm revealed: -When she administered medications to residents, she clicked on the resident's name, scanned the medication cards, dispensed medication in the medication cup, poured water into a cup, took the medication and the water to the resident's room to administer, watched the resident swallow the medication, and then went back to the computer to document the medication was administered. -She administered Resident #1's medication on the morning of 02/08/23. -Resident #1 took a couple of bites of her	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041086	A. BUILDING: _____ B. WING _____	R 02/09/2023

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D 366	Continued From page 24 medication crushed in applesauce, but she did not finish it. -Resident #1 did not drink her gabapentin or polyethylene glycol while she was in the room. -Resident #1 stated she wanted to wait until after she ate her breakfast to take her medication. -Resident #1 usually finished her breakfast by the time she administered morning medications. -She went back to Resident #1's room after breakfast to see if she had taken her medication and she had taken them. -All of Resident #1's 8:00am medications were left in her room. -Resident #1's medications should not have been left in her room. Interview with Resident #1's primary care provider (PCP) on 02/09/23 at 12:52pm revealed: -She did not like or approved of MAs leaving medications in rooms for residents to take. -If staff documented they administered a medication, they were also documenting they observed the resident take the medication. -If a resident was not competent to manage their own medications, then the medications should not be left in the resident's room. -She expected the MAs to observe Resident #1 take her medications prior to leaving her room. Interview with the Healthcare Director (HCD) on 02/09/23 at 3:22pm revealed: -Resident #1 did not have an order to self-administer her own medications. -It was not the facility's protocol to leave medication in a resident's room unless they had an order to self-administer. -It did not matter how slow Resident #1 took her medications, staff had to wait and observe she took them. -MAs were aware no medications were to be left	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 366	Continued From page 25 in a resident's room and received medication training regarding the observing the residents take their medications. -She expected MAs to observe residents take their medications. Interview with the Administrator on 02/09/23 at 4:14pm revealed: -She was not aware medications were left in Resident #1's room. -She expected that no medications were to be left in a resident's room unless the resident had physician's orders to self-administer. -She expected MAs to observe residents take all their medications before documenting administration on the eMAR. -MAs received training in medication administration upon hire including observation of residents taking their medication.	D 366		